

TOTAL ACCESS URGENT CARE

Med Auth Form

1) Visit Type



Occ Med



Work Comp (Specify Body Part) _____

2) Registration

Employee

Authorizing Official

Employee Name _____

Name (Printed) _____

Employee SSN _____

Name (Signature or Verbal) _____

Date of Injury _____

Billing/HR Contact _____

Date _____

By signing or verbally authorizing this authorization, the above referenced company acknowledges and agrees that it is fiscally responsible for all incurred charges, whether work related or non-work related. Charges may be submitted to the above referenced company's Worker's Compensation carrier at the company's discretion but failure to submit charges to the Worker's Compensation carrier does not relieve the company of the responsibility for these charges.

Company Information

Who will be Paying this Claim?



Company Directly



Company's Insurance Carrier

Company Name Lewis and Clark Career Center

Address 2400 Zumbuhl Rd

City St Charles State _____ Zip 63301

Phone 636 443 4960 Ext _____

Secure Fax 636 443 4951

Authorizing Official's Email kallman@stcharlessd.org

If Company's Insurance Carrier is paying, fill info below.

Insurance Name SELF PAY

Claim Number _____

Insurance Contact/Title SELF PAY

Insurance Phone Number _____

3) Evaluation Information

Visit Reason (Select 1)

Drug Screen and/or Breath Alcohol? (Up to 2)

Extra (Employer's Choice)



Pre-Employment



Random



Reasonable Suspicion



Post-Accident



COVID-19 Swab



Other (Write Below) _____



DOT Drug Screen



Non-DOT 5-Panel Drug Screen (Rapid/Default)



Non-DOT 5-Panel Drug Screen (Send-Out)



Non-DOT 10-Panel Drug Screen (Rapid/Default)



Non-DOT 10-Panel Drug Screen (Send-Out)



Breath Alcohol Test



Flu Shot



Hep A



Hep B



Physical



PPD (TB Skin Test)



Other (Write Below) _____

2 Step PPD or TB GOLD

Date: _____

TAUC Registrar Initials: _____